| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

## Filing at a Glance

Company: American Family Life Assurance Company of Columbus

| | | |
|---|---|---|
| Product Name: Payroll, Union and Non-payroll Specified Health Event Application Forms | SERFF Tr Num: AFLA-126789903 | State: Arkansas |
| TOI: H07I Individual Health - Specified Disease - - Limited Benefit | SERFF Status: Closed-Approved-Closed | State Tr Num: 46768 |
| Sub-TOI: H07I.001 Critical Illness | Co Tr Num: A71000RAPPS | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Rosalind Minor |
| | Author: Connie Gates | Disposition Date: 09/24/2010 |
| | Date Submitted: 09/13/2010 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: A71000 applications | Status of Filing in Domicile: Pending |
| Project Number: A71001RAR | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: Similiar versions of the application forms are being filed concurrently in Nebraska. |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Group Market Size: |
| Overall Rate Impact: | Group Market Type: |
| Filing Status Changed: 09/24/2010 | Explanation for Other Group Market Type: |
| | State Status Changed: 09/24/2010 |
| Deemer Date: | Created By: Connie Gates |
| Submitted By: Connie Gates | Corresponding Filing Tracking Number: |

Filing Description:

A filing description letter is attached under the supporting documentation tab.

## Company and Contact

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

**Filing Contact Information**

| | |
|---|---|
| Connie Gates, Policy Analyst | cgates@aflac.com |
| 1932 Wynnton Road | 706-596-5048 [Phone] |
| Columbus, GA 31999 | 706-660-7080 [FAX] |

**Filing Company Information**

| | | |
|---|---|---|
| American Family Life Assurance Company of Columbus | CoCode: 60380 | State of Domicile: Nebraska |
| 1932 Wynnton Road | Group Code: | Company Type: Life and Health |
| Columbus, GA 31999 | Group Name: | State ID Number: |
| (706) 323-3431 ext. [Phone] | FEIN Number: 58-0663085 | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $0.00 |
| Retaliatory? | No |
| Fee Explanation: | $50 per form<br>5 forms x 50= $250 |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| American Family Life Assurance Company of Columbus | $250.00 | 09/13/2010 | 39457658 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 09/24/2010 | 09/24/2010 |

## Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Form | Payroll/Union Application | Connie Gates | 09/24/2010 | 09/24/2010 |
| Form | Payroll/Union Application | Connie Gates | 09/24/2010 | 09/24/2010 |
| Form | Non-payroll Application | Connie Gates | 09/24/2010 | 09/24/2010 |
| Form | Non-payroll Application | Connie Gates | 09/24/2010 | 09/24/2010 |
| Form | Request for Change/Application for Reinstatement and/or Additions | Connie Gates | 09/24/2010 | 09/24/2010 |

### Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Attachments to Form Schedule | Note To Filer | Rosalind Minor | 09/23/2010 | 09/23/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
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| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

# Disposition

Disposition Date: 09/24/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | No |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Form *(revised)*** | Payroll/Union Application | Approved-Closed | Yes |
| **Form** | Payroll/Union Application | Replaced | Yes |
| **Form *(revised)*** | Payroll/Union Application | Approved-Closed | Yes |
| **Form** | Payroll/Union Application | Replaced | Yes |
| **Form *(revised)*** | Non-payroll Application | Approved-Closed | Yes |
| **Form** | Non-payroll Application | Replaced | Yes |
| **Form *(revised)*** | Non-payroll Application | Approved-Closed | Yes |
| **Form** | Non-payroll Application | Replaced | Yes |
| **Form *(revised)*** | Request for Change/Application for Reinstatement and/or Additions | Approved-Closed | Yes |
| **Form** | Request for Change/Application for Reinstatement and/or Additions | Replaced | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

**Amendment Letter**

Submitted Date: 09/24/2010

**Comments:**

Forms are attached to the forms schedule tab.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number | Form Type | Form Name | Action | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| A71001RAR | Application/Enrollment Form | Payroll/Union Application | Revised | | unknown | A71001ARR1 & A71001AARR1 | 57.171 | A71001RAR.pdf |
| A71001L1AR | Application/Enrollment Form | Payroll/Union Application | Initial | | | | 70.904 | A71001L1AR.pdf |
| A71002RAR | Application/Enrollment Form | Non-payroll Application | Revised | | unknown | A71002AARR1 | 71.041 | A71002RAR.pdf |
| A71002RcAR | Application/Enrollment Form | Non-payroll Application | Revised | | unknown | A71002ARR1 | 70.120 | A71002RcAR.pdf |
| A71003RAR | Application/Enrollment Form | Request for Change/Application for Reinstatement and/or Additions | Revised | | unknown | A71003ARR1 | 72.189 | A71003RAR.pdf |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

**Note To Filer**

**Created By:**
Rosalind Minor on 09/23/2010 01:41 PM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
09/24/2010 12:03 PM
**Subject:**
Attachments to Form Schedule
**Comments:**

Connie - There are no attachments to the Form Schedule Tab. It looks like you are attempting to submit replacement forms, but there are no forms attached.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

# Form Schedule

**Lead Form Number: A71001RAR**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 09/24/2010 | A71001RAR | Application/ Enrollment Form | Payroll/Union Application | Revised | Replaced Form #: A71001ARR1 & A71001AARR1 Previous Filing #: unknown | 57.171 | A71001RAR.pdf |
| Approved-Closed 09/24/2010 | A71001L1AR | Application/ Enrollment Form | Payroll/Union Application | Initial | | 70.904 | A71001L1AR.pdf |
| Approved-Closed 09/24/2010 | A71002RAR | Application/ Enrollment Form | Non-payroll Application | Revised | Replaced Form #: A71002AARR1 Previous Filing #: unknown | 71.041 | A71002RAR.pdf |
| Approved-Closed 09/24/2010 | A71002RcAR | Application/ Enrollment Form | Non-payroll Application | Revised | Replaced Form #: A71002ARR1 Previous Filing #: unknown | 70.120 | A71002RcAR.pdf |
| Approved-Closed 09/24/2010 | A71003RAR | Application/ Enrollment Form | Request for Change/Application for Reinstatement and/or Additions | Revised | Replaced Form #: A71003ARR1 Previous Filing #: unknown | 72.189 | A71003RAR.pdf |

[Payroll Union]

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**

[❑Payroll
❑Union]
❑ New
❑ Conversion

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured[/Employee]**

Proposed Insured's[/Employee's] Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Secondary Telephone ( ) _____

E-Mail Address (optional) _____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If yes, Dependent Children must be under age 26 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

[Payroll] Account Name _____ [Payroll] Account No. _____
(Optional)

[Name of Employer _____]

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Does anyone to be covered have any other Specified Health Event or any Lump Sum Critical Illness coverage with Aflac? ❑ Yes ❑ No

If yes, this must be a conversion of that coverage. If yes, give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | [❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Critical Care and Recovery Only (Policy Series A71100)
❑ Plan 2: Critical Care and Recovery with Hospital Intensive Care Unit Benefits (Policy Series A71200) ❑ Pre-Tax or ❑ After-Tax
❑ First-Occurrence Building Benefit Rider (Rider Series A71050) ($500)
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider]**

**[Billing Method:**
❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)
❑ Direct
❑ List Bill

**Mode:**
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 28-Day Biweekly
❑ 01 Semimonthly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

**PLEASE NOTE: If B/D, ACH, C/C, Direct, or List Bill billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.**

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____]

**PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS**

1. Are you currently employed and actively working at your job with the employer listed on the front of this application? ❑ Yes ❑ No
   If No, you are not eligible for coverage.

**PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS**

1. Within the last five years, have you or anyone to be covered been diagnosed with or treated by a member of the medical profession at a health facility for any of the following: ❑ Yes ❑ No
   Heart Attack
   Stroke or Transient Ischemic Attack (TIA)
   Impaired kidney function (other than stones or acute infection)

2. Within the last five years, have you or anyone to be covered had or been advised by a member of the medical profession of the need to have any of the following: ❑ Yes ❑ No
   Major organ transplant
   Coronary artery bypass surgery
   Angioplasty or stent placement

**If either underwriting Question 1 or 2 directly above is answered yes, was it the:**

❑ Proposed Insured[/Employee]? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured[/Employee], a policy will not be issued; therefore do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**IF YOU ARE APPLYING FOR PLAN 1 ONLY, QUESTIONS 3 THROUGH 10 ARE NOT REQUIRED TO BE ANSWERED. PLEASE ONLY COMPLETE QUESTIONS 3 THROUGH 10 IF YOU ARE APPLYING FOR PLAN 2, POLICY SERIES A71200.**

3. Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No

**PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL: _____**
**Proposed Insured/Employee**

4. Are you or anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

5. Have you or anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia or cystic fibrosis? ❑ Yes ❑ No

6. Have you or anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

7. Have you or anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

8. In the last five years, have you or anyone to be covered been diagnosed with or treated by a member of the medical profession for angina (heart related chest pains), congestive heart failure, or diabetes requiring the use of insulin? ❑ Yes ❑ No

9. In the last five years, have you or anyone to be covered had or been advised by a member of the medical profession to have any of the following: heart valve surgery, surgery for congenital heart defects, or coronary atherectomy? ❑ Yes ❑ No

10. In the last 12 months, have you or anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

**If any one of Questions 4 through 10 is answered yes, was it the:**

❑ Proposed Insured[/Employee]? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured[/Employee], a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
- I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.

- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

**SUPPLEMENTAL NOTIFICATION**
**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

- I would prefer to receive an electronic copy of my policy instead of paper. ❑ Yes ❑ No

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's[/Employee's] Signature _____

**[I certify that I personally saw the Proposed Insured[/Employee] when the application was written, and each question was asked of the Proposed Insured[/Employee] and answered as recorded. All answers above are correct to the best of my knowledge.]**

[Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent]

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),**
**CLIENT SERVICES AND ADMINISTRATION,**
**[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.]**

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

## IMPORTANT NOTICE TO PERSONS ON MEDICARE
## THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

[Payroll Union]

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71100 Series)**
**Supplemental Health Insurance Coverage**

[❑ Payroll
❑ Union]
❑ New
❑ Conversion

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured[/Employee]**

Proposed Insured's[/Employee's] Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Secondary Telephone ( ) _____

E-Mail Address (optional) _____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If yes, Dependent Children must be under age 26 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

[Payroll] Account Name _____ [Payroll] Account No. _____
(Optional)

[Name of Employer _____]

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Does anyone to be covered have any other Specified Health Event or any Lump Sum Critical Illness coverage with Aflac? ❑ Yes ❑ No

If yes, this must be a conversion of that coverage. If yes, give current policy number and see Applicant's Statements and Agreements concerning conversions.

Policy Number: _____

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | [❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Critical Care and Recovery Only (Policy Series A71100)
❑ First-Occurrence Building Benefit Rider (Rider Series A71050) ($500) ❑ Pre-Tax
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider** or
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051) ❑ After-Tax
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider]**

**[Billing Method:**

- ❑ Payroll Deduction
- ❑ Bank Draft (B/D, ACH)
- ❑ Credit Card (C/C)
- ❑ Direct
- ❑ List Bill

**Mode:**

- ❑ 01 Weekly
- ❑ 01 14-Day Biweekly
- ❑ 01 28-Day Biweekly
- ❑ 01 Semimonthly
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

**PLEASE NOTE: If B/D, ACH, C/C, Direct, or List Bill billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.**

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____]

**PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS**

1. Are you currently employed and actively working at your job with the employer listed on the front of this application? ❑ Yes ❑ No

   If No, you are not eligible for coverage.

**PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS**

1. Within the last five years, have you or anyone to be covered been diagnosed with or treated by a member of the medical profession at a health facility for any of the following: ❑ Yes ❑ No

   Heart Attack
   Stroke or Transient Ischemic Attack (TIA)
   Impaired kidney function (other than stones or acute infection)

2. Within the last five years, have you or anyone to be covered had or been advised by a member of the medical profession of the need to have any of the following: ❑ Yes ❑ No

   Major organ transplant
   Coronary artery bypass surgery
   Angioplasty or stent placement

**If either underwriting Question 1 or 2 directly above is answered yes, was it the:**

❑ Proposed Insured[/Employee]? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured[/Employee], a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
- I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

- I would prefer to receive an electronic copy of my policy instead of paper. ❑ Yes ❑ No

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's[/Employee's] Signature _____

**[I certify that I personally saw the Proposed Insured[/Employee] when the application was written, and each question was asked of the Proposed Insured[/Employee] and answered as recorded. All answers above are correct to the best of my knowledge.]**

[Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent]

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),**
**CLIENT SERVICES AND ADMINISTRATION,**
**[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.]**

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

## IMPORTANT NOTICE TO PERSONS ON MEDICARE
## THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

### Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Non-Payroll

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured**

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Secondary Telephone ( ) _____

State of Birth _____ E-Mail Address (optional) _____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If yes, Dependent Children must be under age 26 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Name of Employer/Association _____ Account No. _____
(Optional)

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Does anyone to be covered have any other Specified Health Event or any Lump Sum Critical Illness coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | [❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Critical Care and Recovery Only (Policy Series A71100)
❑ Plan 2: Critical Care and Recovery with Hospital Intensive Care Unit Benefits (Policy Series A71200)
❑ First-Occurrence Building Benefit Rider (Rider Series A71050) ($500)
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider]**

**Billing Method:**

- ❑ Direct
- ❑ Bank Draft (B/D, ACH)
- ❑ List Bill
- ❑ Emp. Nonpayroll/Assoc.
- ❑ Credit Card (C/C)

**Modes:**

- ❑ 01 Monthly (B/D & C/C Only)
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

Associate's/Agent's No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

**PLEASE COMPLETE QUESTIONS 1 THROUGH 9 IF APPLYING FOR PLAN 1 OR PLAN 2.**

1. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

   **Any** disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
   **Any** disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
   Chronic obstructive pulmonary disease (COPD)
   Cystic fibrosis
   Type I diabetes
   Impaired kidney function
   Kidney disease or disorder (excluding stones or acute infection) or kidney failure
   Liver disease or disorder (excluding hepatitis A)
   Systemic lupus
   Sickle cell anemia

2. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms? ❑ Yes ❑ No

**If any one of Questions 1 through 8 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy.**
**If the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

9. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

**Additional underwriting may be required.**

**PLEASE ONLY COMPLETE QUESTIONS 10 THROUGH 17**
**IF APPLYING FOR PLAN 2, POLICY SERIES A71200.**

10. Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No

**PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL: _____**
**Proposed Insured/Employee**

11. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

12. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

13. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

14. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

15. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

16. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

**If any one of Questions 11 through 17 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy.**
**If the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 65 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
- I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

**SUPPLEMENTAL NOTIFICATION**
**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

- I would prefer to receive an electronic copy of my policy instead of paper. ❑ Yes ❑ No

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

[Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent]

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),**
**CLIENT SERVICES AND ADMINISTRATION,**
**[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.]**

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Non-Payroll

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured**

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Secondary Telephone ( ) _____

State of Birth _____ E-Mail Address (optional) _____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If yes, Dependent Children must be under age 26 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Name of Employer/Association _____ Account No. _____
(Optional)

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Does anyone to be covered have any other Specified Health Event or any Lump Sum Critical Illness coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | [❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Critical Care and Recovery Only (Policy Series A71100)
❑ Plan 2: Critical Care and Recovery with Hospital Intensive Care Unit Benefits (Policy Series A71200)
❑ First-Occurrence Building Benefit Rider (Rider Series A71050) ($500)
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)
**Options**: ❑ **No rider** ❑ **New rider** ❑**Retain current rider]**

**Billing Method:**

- ❑ Direct
- ❑ Bank Draft (B/D, ACH)
- ❑ List Bill
- ❑ Emp. Nonpayroll/Assoc.
- ❑ Credit Card (C/C)

**Modes:**

- ❑ 01 Monthly (B/D & C/C Only)
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

Associate's/Agent's No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

**PLEASE COMPLETE QUESTIONS 1 THROUGH 9 IF APPLYING FOR PLAN 1 OR PLAN 2.**

1. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

   **Any** disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
   **Any** disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
   Chronic obstructive pulmonary disease (COPD)
   Cystic fibrosis
   Type I diabetes
   Impaired kidney function
   Kidney disease or disorder (excluding stones or acute infection) or kidney failure
   Liver disease or disorder (excluding hepatitis A)
   Systemic lupus
   Sickle cell anemia

2. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms? ❑ Yes ❑ No

**If any one of Questions 1 through 8 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy.**
**If the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

9. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

**Additional underwriting may be required.**

**PLEASE ONLY COMPLETE QUESTIONS 10 THROUGH 17**
**IF APPLYING FOR PLAN 2, POLICY SERIES A71200.**

10. Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No

**PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL: _____**
**Proposed Insured/Employee**

11. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

12. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

13. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

14. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

15. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

16. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

**If any one of Questions 11 through 17 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy.**
**If the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 65 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
- I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

**SUPPLEMENTAL NOTIFICATION**
**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

- I would prefer to receive an electronic copy of my policy instead of paper. ❑ Yes ❑ No

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

**I certify that I personally saw the Proposed Insured when the application was written, and each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge.**

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),**
**CLIENT SERVICES AND ADMINISTRATION,**
**[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.]**

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

**REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT AND/OR ADDITIONS**
**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**American Family Life Assurance Company of Columbus (Aflac)**
[Worldwide Headquarters • Columbus, Georgia 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).
Fax number: 1-800-448-8922]

❑ **Pre-tax** ❑ **After-tax**

**Please Print in Black Ink**

Name of Policyholder _____
Last Name First Name MI

SSN _____ Date of Birth _____

Policy Type _____ Policy Number _____

Associate's/Agent's Signature _____ Writing Number _____
Licensed Resident Associate/Agent

**PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY**

❑ **ADDRESS CHANGE ONLY**

New Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____

❑ **TRANSFERS TO PAYROLL OR UNION BILLING ONLY**

Transfer From _____

Transfer To _____ Transfer To _____
Employer Name Account Number

Department No. _____ Employee No. _____

Amount Remitted $_____ Months _____

Billing Name _____
Last Name First Name MI

Effective Date of Transfer _____

❑ **TRANSFERS TO DIRECT BILLING ONLY**

❑ Bill at Home ❑ Bank Draft ❑ Credit Card

Transfer From: _____

Direct Billing Mode (select one) ❑ Monthly **(Bank Draft/Credit Card Only)** ❑ Quarterly ❑ Semiannual ❑ Annual

Amount Remitted $_____ Months _____

Effective Date of Transfer _____

❑ **NAME CHANGE ONLY**

Name Shown on Policy _____
Last Name First Name MI Title

Change Name To _____
Last Name First Name MI Title

Reason: ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Payroll/Union Billing Name _____(if policy is on payroll/union)

Draftee Name _____(if policy is on bank draft)

Effective Date of Change _____

❑ **DELETIONS ONLY**

Person to be Deleted _____
Last Name First Name MI Title

Sex: ❑ Male ❑ Female

Relationship: ❑ Insured ❑ Spouse ❑ Child

Reason for Deletion ❑ Divorce ❑ Death ❑ Request

Date of Divorce/Death/Request _____

New Policy Holder's/Contract Holder's Full Name_____
Last Name First Name MI

Sex: ❑ Male ❑ Female Birth Date of New Policy Holder/Contract Holder _____

Billing Name (if policy on payroll/union)_____
Last Name First Name MI

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

❑ **ADDITIONS ONLY – Complete applicable questions listed below. Dependent Children must be under age 26 at the time of application.**

Is anyone to be added the mother of a child currently conceived but as yet unborn? ❑ Yes ❑ No
❑ N/A If existing coverage is Plan 1, Policy Series A71100

**Please note, benefits are not payable for pregnancy or childbirth within the first 10 months of the Effective Date of the addition. (Complications of Pregnancy will be covered to the same extent as a Sickness).**

**PLEASE INITIAL: _____**
**Policyholder**

Does anyone to be covered have any other hospital intensive care coverage or does anyone to be covered have a Specified Health Event policy that contains intensive care benefits with Aflac? ❑ Yes ❑ No
If yes, please complete the Supplemental Notification below and be aware that you cannot be covered under this policy without canceling the Aflac policy with intensive care benefits.

**SUPPLEMENTAL NOTIFICATION**
**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC COVERAGE WHICH CONTAINS HOSPITAL INTENSIVE CARE BENEFITS.**

I, _____, am applying for coverage under Aflac's Specified Health Event Policy. I currently have hospital intensive care benefits under Aflac's Intensive Care Policy Number _____ or Specified Health Event Policy Number _____. I understand that I must cancel my existing Aflac Intensive Care coverage or Specified Health Event coverage to be covered under this Specified Health Event policy.
Please cancel:
❑ My Specified Health Event Policy Number _____.
❑ My Hospital Intensive Care Policy Number _____.

I understand that I will be terminating benefits provided for in my current Specified Health Event policy that will not be provided for in the new Specified Health Event policy.

Person(s) to be Added _____
Last Name First Name MI Title

Sex: ❑ Male ❑ Female

Relationship: ❑ Spouse ❑ Child

Reason for Addition: ❑ Marriage ❑ Birth ❑ Request

Date of Marriage/Birth/Request _____

New Policy Holder's/Contract Holder's Full Name _____
Last Name First Name MI

Sex: ❑ Male ❑ Female Birth Date of New Policy Holder/Contract Holder _____

Billing Name (if policy on payroll/union) _____
Last Name First Name MI

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

❑ **REINSTATEMENT OF OR ADDITIONS TO POLICY ONLY – Complete applicable questions listed below.**

**ANSWER QUESTIONS 1 THROUGH 10 FOR REINSTATEMENTS OR ADDITIONS ON PAYROLL OR UNION SALES ONLY.**

1. Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Impaired kidney function (not including stones or acute infection)
   Cerebral vascular insufficiency
   Congenital heart disease (excluding surgically corrected atrial septal defect)
   Heart Attack (two or more)
   Cardiomyopathy
   Stroke or TIA (two or more)
   Liver disease or disorder (excluding Hepatitis A)
   Cystic fibrosis
   Systemic lupus

2. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. In the last five years, has anyone to be covered been diagnosed with or received treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Angina
   Stroke or TIA (single event)
   Coronary artery disease
   Angioplasty, stent placement or bypass surgery
   Chronic obstructive pulmonary disease (COPD)
   Atrial fibrillation
   Arterial blockage
   Heart Attack (single event)
   Peripheral vascular disease

6. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

8. Within the last 12 months, has anyone to be covered received treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

9. Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator? ❑ Yes ❑ No

10. Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness? ❑ Yes ❑ No

**If any one of Questions 1 through 10 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, the policy will not be reinstated; therefore do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**PLEASE COMPLETE QUESTIONS 11 THROUGH 16 ONLY IF YOU ARE REINSTATING OR MAKING ADDITIONS TO PLAN 2, POLICY SERIES A71200, ON PAYROLL OR UNION SALES ONLY.**

11. Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No

**PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL: _____**
**Proposed Insured/Employee**

12. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

13. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia? ❑ Yes ❑ No

14. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

15. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

16. In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

**If any one of Questions 12 through 16 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, the policy will not be reinstated; therefore do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

**COMPLETE NUMBERS 1 THROUGH 9 FOR ADDITIONS AND REINSTATEMENTS ON NONPAYROLL SALES ONLY.**

1. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

   **Any** disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
   **Any** disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
   Chronic obstructive pulmonary disease (COPD)
   Cystic fibrosis
   Type I diabetes
   Impaired kidney function
   Kidney disease or disorder (excluding stones or acute infection) or kidney failure
   Liver disease or disorder (excluding hepatitis A)
   Systemic lupus
   Sickle cell anemia

2. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms? ❑ Yes ❑ No

**If any one of Questions 1 through 8 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, the policy will not be reinstated; therefore do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

9. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

**Additional underwriting may be required.**

**PLEASE COMPLETE QUESTIONS 10 THROUGH 17 ONLY IF YOU ARE REINSTATING OR MAKING ADDITIONS TO PLAN 2, POLICY SERIES A71200, ON NONPAYROLL SALES ONLY.**

10. Are you or anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No

**PLEASE NOTE: Children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL: _____**
**Proposed Insured/Employee**

11. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

12. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

13. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

14. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

15. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

16. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

**If any one of Questions 11 through 17 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, the policy will not be reinstated; therefore do not submit this application.**

**If a Child, are there other children to be covered? ❑Yes ❑ No**

I understand that the reinstated policy will cover only loss resulting from a covered Primary or Secondary Specified Health Event or hospitalization that occurs more than ten days after the date of reinstatement. I understand that the information on this form applies **ONLY** to my Aflac Specified Health Event policy.

I have read, or had read to me, the completed application, and I realize that policy reinstatement is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of

coverage under the policy. I understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy's Reinstatement Provision.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signature_____

Signed and Dated at _____ on _____
City and State Date

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.]**

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET**
**LITTLE ROCK, ARKANSAS 72201-1904**
**Telephone (501) 371-2640 or Toll-Free 1-800-852-5494**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 09/24/2010 |

**Comments:**
A filing description letter signed by a company officer is attached with the following certifications:

I certify that the following forms comply with the requirements of Arkansas Statue Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the forms submitted herewith meet the: applicable provision of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify that the forms submitted herewith meet the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

**Attachment:**
A71000 revapps.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Application | Approved-Closed | 09/24/2010 |

**Comments:**
For your reference the applications previously approved on March 14, 2007, and the stamped approval are attached below.

**Attachments:**
A71000 revapps 20070314 STMPD APPRVL.pdf
A71001ARR1.pdf
A71001AARR1.pdf
A71002ARR1.pdf
A71002AARR1.pdf
A71003ARR1.pdf

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| **Satisfied - Item:** | Outline of Coverage | Approved-Closed | 09/24/2010 |

**Comments:**

The applications submitted for approval will be used with Outline of Coverage Forms A71125AR and A71225AR which were also approved on March 28, 2006. For your convenience a copy of the previously approved Outline of Coverage Forms and stamped approval are attached below.

**Attachments:**

A71125AR.pdf

A71225AR.pdf

A71000 STMPD APPRVL.pdf

*Deborah T. Grantham*
*AIRC, HIA, ACS*
*Second Vice President*
*Compliance Department*

September 13, 2010

Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

NAIC # 60380

**Re: Specified Health Event Payroll and Union Application Forms A71001RAR and A71001L1AR, Non-payroll Application Forms A71002RAR and A71002RcAR, and Request for Change/Application for Reinstatement and/or Additions Form A71003RAR**

Dear Commissioner:

Referenced forms are submitted for your review and approval. Similar versions of these forms were previously approved by your department on March 14, 2007. These applications will be used with Policy Forms A71100 and A71200 which were also approved on March 28, 2006, and will replace the previously approved applications.

Revisions were made in order to simplify the underwriting questions, add a Union option, and update the formatting to be consistent with our more recent applications.

The only difference between A71002RAR and A71002RcAR is that A71002RAR does NOT contain an agent certification statement. Form A71002RAR will be used in situations where the associate/agent is unable to be present at the time of application. Payroll/Union Application Form A71001L1AR differs from Form A71001RAR in that it only offers Plan 1 Policy Form A71100AR.

Any form numbers that were previously approved have been revised by adding an "R" to reflect the changes.

I certify that the following forms comply with the requirements of Arkansas Statue Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act. I further certify the scores for each form are as follows:

| | | **FLESCH Score** |
|---|---|---|
| Payroll and Union Application Form | A71001RAR | 57.17 |
| Payroll and Union Application Form | A71001L1AR | 70.90 |
| Non-payroll Application Form | A71002RAR | 71.04 |
| Non-payroll Application Form | A71002RcAR | 70.12 |
| Request for Change/Application for Reinstatement and/or Additions Form | A71003RAR | 72.19 |

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

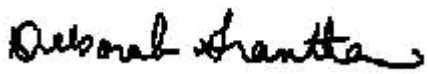
I certify that the forms submitted herewith meet the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

The filing fee of $250 is submitted by EFT in this SERFF filing. FLESCH certification is provided above. A copy of the prior approval is included under the Supporting Documentation tab for your convenience. This will not affect any rates on file that were approved on March 28, 2006. An actuarial memorandum and rates are enclosed for Union.

Aflac reserves the right to alter the format of the forms without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format. We have included brackets in all forms around the address, telephone number, and web site in the event these change in the future. Other bracketed information includes language that may or may not appear based on whether the account is Payroll or Union. The certification statement above the agent's signature may or may not appear based on whether or not the agent is present at the time of application.

This filing has been prepared by Connie Gates. Should you have any questions concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures

Aflac™

COPY

*Rita S. Golden, HIA, AIRC, ACS, MHP*
*Director, Regulatory Compliance*
*Compliance Department*

March 06, 2007

RECEIVED
MAR 20 2007
COMPLIANCE DEPT.

RECEIVED
MAR 12 2007
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

APPROVED
MAR 14 2007
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Mr. Joe Musgrove
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC# 60380

**RE: Application Forms A47001ARR, A47001AARR, A71001ARR1, A71001AARR1, A71002ARR1 and A71002AARR1.**

**Reinstatement Application Forms A18403ARR1, A45003ARR1, A45003DARR1, A46003ARR1, A47003ARR and A71003ARR1.**

Dear Mr. Musgrove:

The above referenced applications are submitted for your review and approval.

The chart below lists the new forms, the policy forms with which the applications will be used, and the original policy approval date of the forms.

| Application Form # | To be used with Policy Form # | Replaces Form # | Policy Approval Date |
|---|---|---|---|
| A18403ARR1 | A18400AR and A1840HAR | A18403RR | 10/27/2006 |
| A45003ARR1 | A-45100-AR, A-45200-AR & A-45300-AR | A45003ARR | 01/04/2007 |
| A45003DARR1 | A-45100-AR, A-45200-AR & A-45300-AR | A45003DARR | 01/04/2007 |
| A46003ARR1 | A46100AR, A46200AR & A46300AR | A46003ARR | 01/04/2007 |
| A47001ARR | A47100AR and A47200AR | A47001AR | 09/13/2006 |
| A47001AARR | A47100AR and A47200AR | A47001AAR | 09/13/2006 |
| A47003ARR | A47100AR and A47200AR | A47003AR | 09/13/2006 |
| A71001ARR1 | A71100AR and A71200AR | A71001ARR | 10/27/2006 |
| A71001AARR1 | A71100AR and A71200AR | A71001AARR | 10/27/2006 |
| A71002ARR1 | A71100AR and A71200AR | A71002ARR | 10/27/2006 |
| A71002AARR1 | A71100AR and A71200AR | A71002AARR | 10/27/2006 |
| A71003ARR1 | A71100AR and A71200AR | A71003ARR | 10/27/2006 |

The changes to the applications are in the underwriting portion of the applications. The following question was added:

Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ☐ Yes ☐ No

**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL: _____**
**Proposed Insured/Employee**

Mr. Joe Musgrove
Arkansas Insurance Department
March 06, 2007

Please note, Application Forms A71001ARR1, A71001AARR1, A71002ARR1 and A71002AARR1 are slightly different from the other Application Forms as the language is more specific to the product. The following question was added:

Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ☐ Yes ☐ No
**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Proposed Insured**

The changes to the reinstatement applications are in the ADDITIONS ONLY section and the underwriting portion. The following questions were added:

*Additions Only section:*

Is anyone to be added the mother of a child currently conceived but as yet unborn? ☐ Yes ☐ No
Please note, benefits are not payable for pregnancy or childbirth within the first 10 months of the Effective Date of the addition. (Complications of Pregnancy will be covered to the same extent as a Sickness).

**PLEASE INITIAL:** _____
**Policyholder**

*Underwriting section:*

Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ☐ Yes ☐ No
**Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Policyholder**

Please note the Reinstatement Application Form A71003ARR1 is slightly different from the other Reinstatement Application Forms as the language is more specific to the product. The following question was added:

Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ☐ Yes ☐ No
**Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Policyholder**

Mr. Joe Musgrove
Arkansas Insurance Department
March 06, 2007

Aflac certifies that the above revisions are the only changes made to the previously approved forms.

The appropriate filing fee, accompanying fee certification form and FLESCH certification form are enclosed. This will not affect any rates that were approved.

I certify that the forms submitted herewith comply with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

This filing has been prepared by Connie Gates. Should you have any questions concerning this filing, please do not hesitate calling her collect at (706) 596-5048, by faxing her at (706) 660-7080 or by e-mailing her at cgates@aflac.com. A return envelope is enclosed for your convenience to reply.

Sincerely,

Rita Golden

Rita S. Golden
RG/CG/cg
Enclosures

Payroll

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured/Employee**

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

Are you applying for Dependent Child(ren) coverage? ❑Yes ❑No
If yes, Dependent Children must be under age 25 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Employee's
Name _____ Relationship _____
(If other than Proposed Insured)

Payroll Account Name _____ Payroll Account No. _____
(Optional)

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.
Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 25.
Policy Number: _____
Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | ❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Specified Health Event Only (Policy Series A71100) ❑ Pre-Tax
❑ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200) or
❑ First Occurrence Building Benefit Rider (Rider Series A71050) ($500) ❑ After-Tax
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)

| **Billing Method:** | **Mode:** | | |
|---|---|---|---|
| ❑ Payroll Deduction | ❑ 01 Weekly | ❑ 01 Semimonthly | ❑ 06 Semiannual |
| ❑ Payroll ACH | ❑ 01 14-Day Biweekly | ❑ 01 Monthly | ❑ 12 Annual |
| | ❑ 01 28-Day Biweekly | ❑ 03 Quarterly | |

Employee ID No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

**PLEASE COMPLETE QUESTIONS 1 THROUGH 11 IF APPLYING FOR PLAN 1 OR PLAN 2.**

1. Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Impaired kidney function (not including stones or acute infection)
   Cerebral vascular insufficiency
   Congenital heart disease (excluding surgically corrected atrial septal defect)
   Heart Attack (two or more)
   Cardiomyopathy
   Stroke or TIA (two or more)
   Liver disease or disorder (excluding Hepatitis A)
   Cystic fibrosis
   Systemic lupus

2. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. In the last five years, has anyone to be covered been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Angina
   Stroke or TIA (single event)
   Coronary artery disease
   Angioplasty, stent placement or bypass surgery
   Chronic obstructive pulmonary disease (COPD)
   Atrial fibrillation
   Arterial blockage
   Heart Attack (single event)
   Peripheral vascular disease

6. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

8. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

9. Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator? ❑ Yes ❑ No

10. Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness? ❑ Yes ❑ No

11. **If any one of Questions 1 through 10 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.**

**PLEASE ONLY COMPLETE QUESTIONS 12 THROUGH 18**
**IF YOU ARE APPLYING FOR PLAN 2, POLICY SERIES A71200.**

12. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Proposed Insured**

13. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

14. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia? ❑ Yes ❑ No

15. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

16. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

18. **If any one of Questions 13 through 17 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

19. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
20. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
21. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
22. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
23. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Outline of Coverage
    - ❑ *Guide To Health Insurance for People with Medicare*
24. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured/Employee or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
25. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 10 or 13 through 17 is answered yes, the policy for which this application is made for the person(s) identified in Item 11 or Item 18 will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

**I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf, and I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.**

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.**

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured/Employee Signature _____

**I certify that I personally saw the Proposed Insured/Employee when the application was written, and each question was asked of the Proposed Insured/Employee and answered as recorded. All answers above are correct to the best of my knowledge.**

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

Writing Associate/Agent: Please complete the following – it will become part of the policy.
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC), CLIENT SERVICES AND ADMINISTRATION,**
**1932 WYNNTON ROAD, COLUMBUS, GEORGIA, 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured/Employee**

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

Are you applying for Dependent Child(ren) coverage? ❑Yes ❑No
If yes, Dependent Children must be under age 25 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Employee's
Name _____ Relationship _____
(If other than Proposed Insured)

Payroll Account Name _____ Payroll Account No. _____
(Optional)

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.
Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 25.
Policy Number: _____
Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | ❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Specified Health Event Only (Policy Series A71100)
❑ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200)
❑ First Occurrence Building Benefit Rider (Rider Series A71050) ($500)
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)

❑ Pre-Tax
or
❑ After-Tax

| **Billing Method:** | **Mode:** | | |
|---|---|---|---|
| ❑ Payroll Deduction | ❑ 01 Weekly | ❑ 01 Semimonthly | ❑ 06 Semiannual |
| ❑ Payroll ACH | ❑ 01 14-Day Biweekly | ❑ 01 Monthly | ❑ 12 Annual |
| | ❑ 01 28-Day Biweekly | ❑ 03 Quarterly | |

Employee ID No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

**PLEASE COMPLETE QUESTIONS 1 THROUGH 11 IF APPLYING FOR PLAN 1 OR PLAN 2.**

1. Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Impaired kidney function (not including stones or acute infection)
   Cerebral vascular insufficiency
   Congenital heart disease (excluding surgically corrected atrial septal defect)
   Heart Attack (two or more)
   Cardiomyopathy
   Stroke or TIA (two or more)
   Liver disease or disorder (excluding Hepatitis A)
   Cystic fibrosis
   Systemic lupus

2. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. In the last five years, has anyone to be covered been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Angina
   Stroke or TIA (single event)
   Coronary artery disease
   Angioplasty, stent placement or bypass surgery
   Chronic obstructive pulmonary disease (COPD)
   Atrial fibrillation
   Arterial blockage
   Heart Attack (single event)
   Peripheral vascular disease

6. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

8. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

9. Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator? ❑ Yes ❑ No

10. Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness? ❑ Yes ❑ No

11. **If any one of Questions 1 through 10 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.**

**PLEASE ONLY COMPLETE QUESTIONS 12 THROUGH 18**
**IF YOU ARE APPLYING FOR PLAN 2, POLICY SERIES A71200.**

12. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Proposed Insured**

13. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

14. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia? ❑ Yes ❑ No

15. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

16. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

18. **If any one of Questions 13 through 17 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

19. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
20. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
21. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
22. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
23. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Outline of Coverage
    - ❑ *Guide To Health Insurance for People with Medicare*
24. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured/Employee or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
25. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 10 or 13 through 17 is answered yes, the policy for which this application is made for the person(s) identified in Item 11 or Item 18 will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

**I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf, and I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.**

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.**

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured/Employee Signature _____

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

Writing Associate/Agent: Please complete the following – it will become part of the policy.
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC), CLIENT SERVICES AND ADMINISTRATION,**
**1932 WYNNTON ROAD, COLUMBUS, GEORGIA, 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Non-Payroll

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured**

Proposed Insured's Name _____ (Last) _____ (First) _____ (MI)

DOB _____ (Month/Day/Year) Sex _____ SSN _____ - _____ - _____

State of Birth: _____ Are you applying for Dependent Child(ren) coverage? ❑Yes ❑No
If yes, Dependent Children must be under age 25 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ (Last) _____ (First) _____ (MI) DOB _____ (Month/Day/Year) Sex _____

Address _____ (Street or Post Office Box) _____ (Apt. No.)

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Name of Employer/Association _____ Account No. _____ (Optional)

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.
Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 26.
Policy Number: _____
Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | ❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Specified Health Event Only (Policy Series A71100)
❑ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200)
❑ First Occurrence Building Benefit Rider (Rider Series A71050) ($500)
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)

**Billing Method:**
❑ Direct
❑ Bank Draft (B/D, ACH)
❑ List Bill
❑ Emp. Nonpayroll/Assoc.
❑ Credit Card (C/C)

**Modes:**
❑ 01 Monthly (B/D & C/C Only)
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Card Name _____

Card No. _____ Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (Aflac) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to Aflac. Cancellation will be effective on the first day of the month following Aflac's receipt of notice to cancel.

Signature _____ Date _____

Associate's/Agent's No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

**PLEASE COMPLETE QUESTIONS 1 THROUGH 10 IF APPLYING FOR PLAN 1 OR PLAN 2.**

1. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

   **Any** disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
   **Any** disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
   Chronic obstructive pulmonary disease (COPD)
   Cystic fibrosis
   Type I diabetes
   Impaired kidney function
   Kidney disease or disorder (excluding stones or acute infection) or kidney failure
   Liver disease or disorder (excluding hepatitis A)
   Systemic lupus
   Sickle cell anemia

2. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms? ❑ Yes ❑ No

9. **If any one of Questions 1 through 8 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

10. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

**Additional underwriting may be required.**

**PLEASE ONLY COMPLETE QUESTIONS 11 THROUGH 19**
**IF APPLYING FOR PLAN 2, POLICY SERIES A71200.**

11. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Proposed Insured**

12. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

13. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

14. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

15. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

16. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

18. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

19. **If any one of Questions 12 through 18 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

20. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
21. I understand that the policy I am applying for will not cover any person who has attained age 65 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
22. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
23. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
24. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Outline of Coverage
    - ❑ *Guide to Health Insurance for People with Medicare*
25. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
26. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 8 or 12 through 18 is answered yes, the policy for which this application is made for the person(s) identified in Item 9 or Item 19 will be void, and coverage will continue for this person under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.**

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

**I certify that I personally saw the Proposed Insured when the application was written, and each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge.**

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

Writing Associate/Agent: Please complete the following – it will become part of the policy.

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC), CLIENT SERVICES AND ADMINISTRATION,**
**1932 WYNNTON ROAD, COLUMBUS, GEORGIA, 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:

**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Non-Payroll

**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**(A71000 Series)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured**

Proposed Insured's Name _____ (Last) _____ (First) _____ (MI)

DOB _____ (Month/Day/Year) Sex _____ SSN _____ - _____ - _____

State of Birth: _____ Are you applying for Dependent Child(ren) coverage? ❑Yes ❑No
If yes, Dependent Children must be under age 25 at the time of application.

**Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ (Last) _____ (First) _____ (MI) DOB _____ (Month/Day/Year) Sex _____

Address _____ (Street or Post Office Box) _____ (Apt. No.)

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Name of Employer/Association _____ Account No. _____ (Optional)

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.
Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 26.
Policy Number: _____
Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Series A71200) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

| **Check Coverage Desired:** | ❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

❑ Plan 1: Specified Health Event Only (Policy Series A71100)
❑ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200)
❑ First Occurrence Building Benefit Rider (Rider Series A71050) ($500)
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)

**Billing Method:**
❑ Direct
❑ Bank Draft (B/D, ACH)
❑ List Bill
❑ Emp. Nonpayroll/Assoc.
❑ Credit Card (C/C)

**Modes:**
❑ 01 Monthly (B/D & C/C Only)
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Card Name _____

Card No. _____ Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (Aflac) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to Aflac. Cancellation will be effective on the first day of the month following Aflac's receipt of notice to cancel.

Signature _____ Date _____

Associate's/Agent's No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

**PLEASE COMPLETE QUESTIONS 1 THROUGH 10 IF APPLYING FOR PLAN 1 OR PLAN 2.**

1. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

   **Any** disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
   **Any** disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
   Chronic obstructive pulmonary disease (COPD)
   Cystic fibrosis
   Type I diabetes
   Impaired kidney function
   Kidney disease or disorder (excluding stones or acute infection) or kidney failure
   Liver disease or disorder (excluding hepatitis A)
   Systemic lupus
   Sickle cell anemia

2. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms? ❑ Yes ❑ No

9. **If any one of Questions 1 through 8 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

10. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

**Additional underwriting may be required.**

**PLEASE ONLY COMPLETE QUESTIONS 11 THROUGH 19**
**IF APPLYING FOR PLAN 2, POLICY SERIES A71200.**

11. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Proposed Insured**

12. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

13. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

14. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

15. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

16. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

18. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

19. **If any one of Questions 12 through 18 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

20. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
21. I understand that the policy I am applying for will not cover any person who has attained age 65 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Series A71200) reduce to half at age 70.**
22. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
23. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
24. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Outline of Coverage
    - ❑ *Guide to Health Insurance for People with Medicare*
25. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
26. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 8 or 12 through 18 is answered yes, the policy for which this application is made for the person(s) identified in Item 9 or Item 19 will be void, and coverage will continue for this person under the terms of the previous policy, if such policy remains in force. (b) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (c) The Pre-Existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-Existing Conditions provision in the new policy will run from the new policy's Effective Date.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.**

I, _____, am applying for Aflac's Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Specified Health Event policy.

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.**

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

Writing Associate/Agent: Please complete the following – it will become part of the policy.
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC), CLIENT SERVICES AND ADMINISTRATION,**
**1932 WYNNTON ROAD, COLUMBUS, GEORGIA, 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at AFLAC fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

**REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT AND/OR ADDITIONS**
**SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY**
**ATTENTION: POLICYHOLDER SERVICES (PHS)**
**American Family Life Assurance Company of Columbus (Aflac)**
Worldwide Headquarters • Columbus, Georgia 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).
Fax number: 1-800-448-8922

❑ **Pre-tax** ❑ **After-tax**

**Please Print in Black Ink**

Name of Policyholder _____
Last Name First Name MI

SSN _____ Date of Birth _____

Policy Type _____ Policy Number _____

Associate's/Agent's Signature _____ Writing Number _____
Licensed Resident Associate/Agent

**PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY**

❑ **ADDRESS CHANGE ONLY**

New Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____

❑ **TRANSFERS TO PAYROLL BILLING ONLY**

Transfer From _____

Transfer To _____ Transfer To _____
Employer Name Account Number

Department No. _____ Employee No. _____

Amount Remitted $ _____ Months _____

Billing Name _____
Last Name First Name MI

Effective Date of Transfer _____

❑ **TRANSFERS TO DIRECT BILLING ONLY**

❑ Bill at Home ❑ Bank Draft ❑ Credit Card

Transfer From: _____

Direct Billing Mode (select one) ❑ Monthly **(Bank Draft/Credit Card Only)** ❑ Quarterly ❑ Semiannual ❑ Annual

Amount Remitted $_____ Months _____

Effective Date of Transfer _____

❑ **NAME CHANGE ONLY**

Name Shown on Policy _____

Last Name First Name MI Title

Change Name To _____

Last Name First Name MI Title

Reason: ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Payroll Billing Name _____(if policy is on payroll)

Draftee Name _____(if policy is on bank draft)

Effective Date of Change _____

❑ **DELETIONS ONLY**

Person to be Deleted _____

Last Name First Name MI Title

Sex: ❑ Male ❑ Female

Relationship: ❑ Insured ❑ Spouse ❑ Child

Reason for Deletion ❑ Divorce ❑ Death ❑ Request

Date of Divorce/Death/Request _____

New Policy Holder's/Contract Holder's Full Name_____

Last Name First Name MI

Sex: ❑ Male ❑ Female Birth Date of New Policy Holder/Contract Holder _____

Billing Name (only applicable if policy on payroll)_____

Last Name First Name MI

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

❑ **ADDITIONS ONLY – Complete applicable questions listed below.**

Is anyone to be added the mother of a child currently conceived but as yet unborn? ❑ Yes ❑ No
❑ N/A If existing coverage is Plan 1, Policy Series A71100

**Please note, benefits are not payable for pregnancy or childbirth within the first 10 months of the Effective Date of the addition. (Complications of Pregnancy will be covered to the same extent as a Sickness).**

**PLEASE INITIAL:** _____
**Policyholder**

Does anyone to be covered have any other hospital intensive care coverage or does anyone to be covered have a Specified Health Event policy that contains intensive care benefits with Aflac? ❑ Yes ❑ No
If yes, please complete the Supplemental Notification below and be aware that you cannot be covered under this policy without canceling the Aflac policy with intensive care benefits.

**SUPPLEMENTAL NOTIFICATION**
**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC COVERAGE WHICH CONTAINS HOSPITAL INTENSIVE CARE BENEFITS.**

I, _____, am applying for coverage under Aflac's Specified Health Event Policy. I currently have hospital intensive care benefits under Aflac's Intensive Care Policy Number _____ or Specified Health Event Policy Number _____. I understand that I must cancel my existing Aflac Intensive Care coverage or Specified Health Event coverage to be covered under this Specified Health Event policy.
Please cancel:
❑ My Specified Health Event Policy Number _____.
❑ My Hospital Intensive Care Policy Number _____.

I understand that I will be terminating benefits provided for in my current Specified Health Event policy that will not be provided for in the new Specified Health Event policy.

Person(s) to be Added _____
Last Name First Name MI Title

Sex: ❑ Male ❑ Female

Relationship: ❑ Spouse ❑ Child

Reason for Addition: ❑ Marriage ❑ Birth ❑ Request

Date of Marriage/Birth/Request _____

New Policy Holder's/Contract Holder's Full Name _____
Last Name First Name MI

Sex: ❑ Male ❑ Female Birth Date of New Policy Holder/Contract Holder _____

Billing Name (only applicable if policy on payroll) _____
Last Name First Name MI

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

❑ **REINSTATEMENT OF OR ADDITIONS TO POLICY ONLY – Complete applicable questions listed below.**

**ANSWER QUESTIONS 1 THROUGH 11 FOR REINSTATEMENTS OR ADDITIONS ON PAYROLL SALES ONLY.**

1. Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Impaired kidney function (not including stones or acute infection)
   Cerebral vascular insufficiency
   Congenital heart disease (excluding surgically corrected atrial septal defect)
   Heart Attack (two or more)
   Cardiomyopathy
   Stroke or TIA (two or more)
   Liver disease or disorder (excluding Hepatitis A)
   Cystic fibrosis
   Systemic lupus

2. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. In the last five years, has anyone to be covered been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

   Angina
   Stroke or TIA (single event)
   Coronary artery disease
   Angioplasty, stent placement or bypass surgery
   Chronic obstructive pulmonary disease (COPD)
   Atrial fibrillation
   Arterial blockage
   Heart Attack (single event)
   Peripheral vascular disease

6. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

8. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

9. Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator? ❑ Yes ❑ No

10. Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness? ❑ Yes ❑ No

11. **If any one of Questions 1 through 10 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) so designated will not be covered under the policy.**

**If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.**

**PLEASE COMPLETE QUESTIONS 12 THROUGH 18**
**ONLY IF YOU ARE REINSTATING OR MAKING ADDITIONS TO PLAN 2, POLICY SERIES A71200.**

12. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
**Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Policyholder**

13. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

14. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease, or sickle cell anemia? ❑ Yes ❑ No

15. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

16. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

18. **If any one of Questions 13 through 17 is answered yes, was it the:**

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.**

**COMPLETE NUMBERS 1 THROUGH 10 FOR ADDITIONS AND REINSTATEMENTS ON NONPAYROLL SALES ONLY.**

1. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

**Any** disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
**Any** disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
Chronic obstructive pulmonary disease (COPD)
Cystic fibrosis
Type I diabetes
Impaired kidney function
Kidney disease or disorder (excluding stones or acute infection) or kidney failure
Liver disease or disorder (excluding hepatitis A)
Systemic lupus
Sickle cell anemia

2. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these symptoms? ❑ Yes ❑ No

9. **If any one of Questions 1 through 8 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

10. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

**Additional underwriting may be required.**

**PLEASE COMPLETE QUESTIONS 11 THROUGH 19**
**ONLY IF YOU ARE REINSTATING OR MAKING ADDITIONS TO PLAN 2, POLICY SERIES A71200.**

11. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
**Please note, children born within 10 months of the reinstatement Effective Date of this policy will not be covered for any losses or confinements, for Benefits A & B of Plan 2, that occur or begin within the first 28 days of life.**

**PLEASE INITIAL:** _____
**Policyholder**

12. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

13. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

14. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

15. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

16. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

18. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

19. **If any one of Questions 12 through 18 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren).

_____.

**Any person(s) so designated will not be covered under the policy.**
**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

I understand that the reinstated policy will cover only loss resulting from a covered Primary or Secondary Specified Health Event or hospitalization that occurs more than ten days after the date of reinstatement. I understand that the information on this form applies **ONLY** to my Aflac Specified Health Event policy.

I have read, or had read to me, the completed application, and I realize that policy reinstatement is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy. I understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy's Reinstatement Provision.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature_____

Signed and Dated at _____ on _____
City and State Date

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
**ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION**
**1200 WEST THIRD STREET**
**LITTLE ROCK, ARKANSAS 72201-1904**
**Telephone (501) 371-2640 or Toll-Free 1-800-852-5494**

**MAKE CHECKS PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**
**VISIT OUR WEB SITE AT AFLAC.COM.**

**FOR WORLDWIDE HEADQUARTERS USE ONLY**

PTD _____ No. Months Dropped _____
Lapsed _____ $ Applied _____
Reinstated _____ No. Months _____
Premiums Applied From _____ New PTD _____
Initials _____

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)**
**Worldwide Headquarters • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999**
**TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)**

**The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.**

# SPECIFIED HEALTH EVENT INSURANCE POLICY

**Supplemental Health Insurance Coverage**

## Outline of Coverage for Policy Form Series A71100
## THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

**If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* furnished by Aflac.**

**(1) Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

**(2) Specified Health Event Insurance Coverage** is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

Form A92397

**(3) Benefits:** Subject to the Pre-existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Specified Health Event that occurs while coverage is in force.

**A. FIRST-OCCURRENCE BENEFIT:** Aflac will pay the following benefit amount for each covered person when he or she is first diagnosed as having had a Primary Specified Health Event:

**Named Insured/Spouse**
$5,000 (Lifetime maximum $5,000 per covered person)

**Dependent Children**
$7,500 (Lifetime maximum $7,500 per covered person)

This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy.

**B. REOCCURRENCE BENEFIT:** If benefits have been paid to a covered person under A above, Aflac will pay $2,500 (two thousand five hundred dollars) if such covered person is later diagnosed as having had a subsequent Primary Specified Health Event.

**For Benefit B to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit A or Benefit B became payable. No lifetime maximum.**

**C. HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):** When a covered person requires Hospital Confinement for the treatment of a covered Primary Specified Health Event, Aflac will pay $300 (three hundred dollars) per day for each day a covered person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Primary Specified Health Event that occur within 500 days following the occurrence of the most recent covered Primary Specified Health Event.** No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

**Benefits are not payable on the same day as the Continuing Care Benefit (D). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid.**

Benefits D through G will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

**D. CONTINUING CARE BENEFIT:** If, as the result of a covered Primary Specified Health Event, a covered person receives any of the following treatments from a licensed Physician, Aflac will pay $125 (one hundred twenty-five dollars) each day a covered person is charged:

1. rehabilitation therapy
2. physical therapy
3. speech therapy
4. occupational therapy
5. respiratory therapy
6. dietary therapy/consultation
7. home health care
8. dialysis
9. hospice care
10. extended care
11. Physician visits
12. nursing home care

Treatment is limited to 75 days for continuing care commencing within 180 days following the occurrence of the most recent covered Primary Specified Health Event. Daily maximum for this benefit is $125 (one hundred twenty-five dollars) regardless of the number of treatments received.

Form A92397

**Benefits are not payable on the same day as the Hospital Confinement Benefit (C). If the Hospital Confinement Benefit (C) and the Continuing Care Benefit (D) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.**

**E. AMBULANCE BENEFIT:** If, due to a covered Primary Specified Health Event, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event, we will pay $2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event. **Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

**F. TRANSPORTATION BENEFIT:** If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty cents) per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the Hospital or medical facility and the residence of the covered person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to $1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. **Transportation Benefits are not**

**payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON.** No lifetime maximum.

**G. LODGING BENEFIT:** Aflac will pay the charges incurred up to $75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered Primary Specified Health Event. **Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

**H. SECONDARY SPECIFIED HEALTH EVENT BENEFIT:** Aflac will pay $250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. **This benefit is limited to one Coronary Angioplasty per 30-day period.** No lifetime maximum.

**I. WAIVER OF PREMIUM BENEFIT:**

**Employed:** If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

**Not Employed:** If you, due to a Primary Specified Health Event (as defined in Part 1, Item R of the policy), are completely unable to perform three or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

**J. CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction;
4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
5. You re-establish premium payments through:
   a. your new employer's payroll deduction process, or
   b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and

2. We receive premiums for at least six consecutive months.

**"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.**

**(4) Optional Benefits:**

**FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A71050) Applied for ❑ Yes ❑ No**

The First-Occurrence Building Benefit as defined in the policy, will be increased by $500 (five hundred dollars) on each rider anniversary date while this rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time of a Primary Specified Health Event, subject to Part 2 of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for this rider after the payment of benefits.)

**PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71051)**
**Applied for ❑ Yes ❑ No**

A covered person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. "Primary Specified Health Event" includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of this rider.

Aflac will pay $500 per month while a covered person remains in Primary Specified Health Event Recovery upon receipt of written proof of loss from that person's Physician.

For Periods of Primary Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

**PRE-EXISTING CONDITIONS:** Benefits for a Primary Specified Health Event that is caused by a Pre-existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date of the rider.

**LIMITATIONS AND EXCLUSIONS FOR RIDER SERIES A71051 ONLY:**

**A.** Benefits for a Primary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person.

**B. This rider does not cover losses or confinements caused by or resulting from:**

1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

2. Participating in any sport or sporting activity for wage, compensation, or profit.

3. Intentionally self-inflicting bodily Injury or attempting suicide.

4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

**(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):**

**A.** Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary or Secondary Specified Health Event at a time per covered person.

**B. The policy does not cover losses or confinements caused by or resulting from:**

1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

2. Participating in any sport or sporting activity for wage, compensation, or profit.

3. Intentionally self-inflicting bodily Injury or attempting suicide.

4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

A "Pre-Existing Condition" is an illness, disease, disorder, or Injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date.

**(6) Renewability:** The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

**RETAIN FOR YOUR RECORDS.**
**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.**
**THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE**
**GOVERNING CONTRACTUAL PROVISIONS.**

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)**
**Worldwide Headquarters • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999**
**TOLL-FREE 1.800.99.AFLAC (1.800.992.3522)**

**The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.**

# SPECIFIED HEALTH EVENT INSURANCE POLICY
## Supplemental Health Insurance Coverage

## Outline of Coverage for Policy Form Series A71200
## THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

**If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* furnished by Aflac.**

**(1) Read Your Policy Carefully:** This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

**(2) Specified Health Event Insurance Coverage** is designed to supplement your existing accident and Sickness coverage only when certain losses occur as a result of Specified Health Events. Primary Specified Health Events are: Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, Paralysis, or Sudden Cardiac Arrest occurring after the Effective Date of coverage. Secondary Specified Health Events are: Coronary Angioplasty, with or without stents, occurring after the Effective Date of coverage. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by the provisions in Part (5).

Form A92398

**(3) Benefits:** Subject to the Pre-existing Conditions provision, if applicable, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Specified Health Event that occurs while coverage is in force.

**IMPORTANT: BENEFITS A, B, and J REDUCE BY ONE-HALF FOR LOSSES INCURRED ON OR AFTER THE POLICY ANNIVERSARY DATE FOLLOWING THE 70TH BIRTHDAY OF A COVERED PERSON.**

Subject to Part 2, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

**BENEFITS FOR HOSPITAL INTENSIVE CARE UNIT CONFINEMENTS:**

**A. HOSPITAL INTENSIVE CARE UNIT BENEFIT:** Aflac will pay the following benefits when a covered person incurs a charge for confinement in a Hospital Intensive Care Unit or a Step-Down Intensive Care Unit for a covered Sickness or Injury:

**1. Confinement in a Hospital Intensive Care Unit:**

| Sickness | Injury | Days |
|---|---|---|
| $ 700 per day | $ 800 per day | 1–7 |
| $1,200 per day | $1,300 per day | 8–15 |

**2. Confinement in a Step-Down Intensive Care Unit Benefit:**

| Sickness | Injury | Days |
|---|---|---|
| $350 per day | $350 per day | 1–15 |

**IMPORTANT:** Benefits A1 and A2 are each limited to 15 days per Period of Confinement. Benefit A2 is also payable for confinement in a Hospital Intensive Care Unit after exhaustion of benefits payable under A1 above. No lifetime maximum.

**IMPORTANT: Benefits payable under A1 or A2 above are not payable on the same day. If a covered person is charged for both on the same day, only the highest eligible benefit will be paid. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable. No lifetime maximum.**

**B. PROGRESSIVE BENEFIT FOR HOSPITAL INTENSIVE CARE UNIT/STEP-DOWN INTENSIVE CARE UNIT CONFINEMENT:** Two dollars indemnity will accumulate for the Named Insured and the covered spouse for each calendar month the policy remains in force after the Effective Date. This accumulated indemnity, if any, will be paid in addition to the Hospital Intensive Care Unit Benefit A1 and A2 for each day of Hospital Intensive Care Unit confinement for which benefits under A1 or A2 are payable. This Progressive Benefit will cease to build on the policy anniversary date following the 65th birthday of a covered person. Any amount accrued at the time this benefit ceases to build for a covered person will continue to be added to the benefit amount for all Hospital Intensive Care Unit/Step-Down Hospital Intensive Care Unit confinements commencing prior to the policy anniversary date following the 70th birthday of the covered person. **THIS ACCUMULATED BENEFIT REDUCES AT AGE 70.** This accumulated benefit will be reduced by one-half for Hospital Intensive Care Unit/Step-Down Intensive Care Unit confinements commencing on or after the policy anniversary date following the 70th birthday of a covered person. **This benefit is not applicable and will not accrue to any covered person who has attained age 65 prior to the Effective Date of the policy**. The Named Insured and covered spouse, if any, are the only persons eligible for this benefit if One-Parent Family or Two-Parent Family coverage is in force. Dependent Children do not qualify for this benefit. When a spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such spouse, provided the spouse has not yet attained age 65.

**BENEFITS FOR PRIMARY SPECIFIED HEALTH EVENTS:**

**Subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy provisions, Benefits F through H will be paid for care received within 180 days following the occurrence of a covered Primary Specified Health Event. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered Primary Specified Health Event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.**

**C. FIRST-OCCURRENCE BENEFIT:** Aflac will pay the following benefit amount for each covered person when he or she is first diagnosed as having had a Primary Specified Health Event:

**Named Insured/Spouse**
$5,000 (Lifetime maximum $5,000 per covered person)

**Dependent Children**
$7,500 (Lifetime maximum $7,500 per covered person)

This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy.

**D. REOCCURRENCE BENEFIT:** If benefits have been paid to a covered person under C above, Aflac will pay $2,500 (two thousand five hundred dollars) if such covered person is later diagnosed as having had a subsequent Primary Specified Health Event.

**For Benefit D to be payable, the Primary Specified Health Event must occur more than 180 days after the date Benefit C or Benefit D became payable. No lifetime maximum.**

**E. HOSPITAL CONFINEMENT BENEFIT (includes confinement in a U.S. government Hospital):** When a covered person requires Hospital Confinement for the treatment of a covered Primary Specified Health Event, Aflac will pay $300 (three hundred dollars) per day for each day a covered person is charged as an inpatient. **This benefit is limited to confinements for the treatment of a covered Primary Specified Health Event that occur within 500 days following the occurrence of the most recent covered Primary Specified Health Event.** No lifetime maximum.

Hospital Confinement Benefits are payable for only one covered Primary Specified Health Event at a time per covered person. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

**F. CONTINUING CARE BENEFIT:** If, as the result of a covered Primary Specified Health Event, a covered person receives any of the following treatments from a licensed Physician, Aflac will pay $125 (one hundred twenty-five dollars) each day a covered person is charged:

1. rehabilitation therapy
2. physical therapy
3. speech therapy
4. occupational therapy
5. respiratory therapy
6. dietary therapy/consultation
7. home health care
8. dialysis
9. hospice care
10. extended care
11. Physician visits
12. nursing home care

Treatment is limited to 75 days for continuing care commencing within 180 days following the occurrence of the most recent covered Primary Specified Health Event. Daily maximum for this benefit is $125 (one hundred twenty-five dollars) regardless of the number of treatments received.

Form A92398

**Benefits are not payable on the same day as the Hospital Confinement Benefit (E). If the Hospital Confinement Benefit (E) and the Continuing Care Benefit (F) are payable on the same day, only the highest eligible benefit will be paid. No lifetime maximum.**

**G. TRANSPORTATION BENEFIT:** If a covered person requires special medical treatment that has been prescribed by the local attending Physician for a covered Primary Specified Health Event, Aflac will pay 50 cents (fifty cents) per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the Hospital or medical facility and the residence of the covered person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a Dependent Child and commercial travel is necessary, we will pay this benefit for up to two adults to accompany the Dependent Child. The benefit amount payable is limited to $1,500 (one thousand five hundred dollars) per occurrence of a covered Primary Specified Health Event. **Transportation Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event. THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON.** No lifetime maximum.

**H. LODGING BENEFIT:** Aflac will pay the charges incurred up to $75 (seventy-five dollars) per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered Primary Specified Health Event at a Hospital or medical facility. The Hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a

covered Primary Specified Health Event. **Lodging Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

**BENEFIT FOR SECONDARY SPECIFIED HEALTH EVENTS:**

Subject to the Pre-existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

**I. SECONDARY SPECIFIED HEALTH EVENT BENEFIT**: Aflac will pay $250 (two hundred fifty dollars) for each covered person under the policy when he or she has a Coronary Angioplasty, with or without stents. **This benefit is limited to one Coronary Angioplasty per 30-day period.** No lifetime maximum.

**MISCELLANEOUS BENEFITS:**

Subject to the Pre-Existing Conditions provision, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits to a covered person, as applicable:

**J. MAJOR HUMAN ORGAN TRANSPLANT BENEFIT:** Aflac will pay $25,000 (twenty-five thousand dollars) as a result of a Major Human Organ Transplant procedure when a covered person is confined in a Hospital and receives one or more of the following human organs: kidney, liver, heart, lung, or pancreas. Transplant procedures involving more than one major organ will be considered to be one organ transplant procedure. **This benefit is not payable for transplants involving mechanical or nonhuman organs and is limited to one procedure per 180-day period.** No lifetime maximum.

**K. AMBULANCE BENEFIT:** If, due to a covered Primary Specified Health Event or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit for a covered Sickness or Injury, a covered person requires ground ambulance transportation to or from a Hospital, Aflac will pay $250 (two hundred fifty dollars). If air ambulance transportation is required due to a covered Primary Specified Health Event for a covered Sickness or Injury, or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit, we will pay $2,000 (two thousand dollars). A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a Primary Specified Health Event or confinement in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit for a covered Sickness or Injury. **Ambulance Benefits are not payable beyond the 180th day following the occurrence of a covered Primary Specified Health Event.** No lifetime maximum.

**L. WAIVER OF PREMIUM BENEFIT:**

**Employed:** If you, due to a Primary Specified Health Event (as defined in Part 1, Item T of the policy), are completely unable to do all of the usual and customary duties of your occupation for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement and a Physician's statement of your inability to perform said duties, and may each month thereafter require a Physician's statement that total inability continues.

**Not Employed:** If you, due to a Primary Specified Health Event (as defined in Part 1, Item T of the policy), are completely unable to perform three or more of the Activities of Daily Living (ADLs) without the assistance of another person for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require a Physician's statement of your inability to perform said activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will start again and be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

While this benefit is being paid, Aflac may ask for and use an independent consultant to determine whether you can perform an ADL.

**M. CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction;
4. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
5. You re-establish premium payments through:
   a. your new employer's payroll deduction process, or
   b. direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. We receive premiums for at least six consecutive months.

**"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.**

**(4) Optional Benefits:**

**FIRST-OCCURRENCE BUILDING BENEFIT RIDER: (Series A71050) Applied for ❑ Yes ❑ No**

The First-Occurrence Building Benefit as defined in the policy, will be increased by $500 (five hundred dollars) on each rider anniversary date while this rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time of a Primary Specified Health Event, subject to Part 2 of the policy, for that covered person, whichever occurs first. However, regardless of the age of the covered person on the Effective Date of this rider, this benefit will accrue for a period of at least five years unless a Primary Specified Health Event is diagnosed prior to the fifth year of coverage. (If this is Individual coverage, no further premium will be billed for this rider after the payment of benefits.)

**PRIMARY SPECIFIED HEALTH EVENT RECOVERY BENEFIT RIDER: (Series A71051)**
**Applied for ❑ Yes ❑ No**

A covered person will be considered in Specified Health Event Recovery if he or she continues to be under the active care and treatment by a Physician for a covered Primary Specified Health Event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered Primary Specified Health Event. “Primary Specified Health Event” includes Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure, Major Human Organ Transplant, Major Third-Degree Burns, Persistent Vegetative State, Coma, or Paralysis occurring after the Effective Date of this rider.

Aflac will pay $500 per month while a covered person remains in Primary Specified Health Event Recovery upon receipt of written proof of loss from that person’s Physician.

For Periods of Primary Specified Health Event Recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

**PRE-EXISTING CONDITIONS:** Benefits for a Primary Specified Health Event that is caused by a Pre-existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date of the rider.

**LIMITATIONS AND EXCLUSIONS FOR RIDER SERIES A71051 ONLY:**

**A.** Benefits for a Primary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary Specified Health Event at a time per covered person.

**B. This rider does not cover losses or confinements caused by or resulting from:**

1. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

2. Participating in any sport or sporting activity for wage, compensation, or profit.

3. Intentionally self-inflicting bodily Injury or attempting suicide.

4. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

**(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):**

**A.** Benefits payable under Part 5, A, B, and J of the policy will be reduced by one-half for losses that begin on or after the policy anniversary date following the 70th birthday of a covered person.

**B.** Benefits are not payable under Part 5, A1 and B, **Hospital Intensive Care Unit**, for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency room or outpatient surgery units; or other facilities that do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable under Part 5, A2 and B, **Step-Down Intensive Care Unit**, for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, beds, wards, or private or semiprivate room with or without telemetry monitoring equipment, observation units located in emergency room or outpatient surgery units, emergency rooms, labor or delivery rooms; or other facilities that do not meet the standards for a Step-Down Intensive Care Unit.

Form A91345

**C.** Benefits are not payable for losses or confinements that begin or occur before the policy Effective Date or after termination of the policy.

**D.** Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. Benefits are payable for only one covered Primary or Secondary Specified Health Event at a time per covered person.

**E. The policy does not cover losses or confinements caused by or resulting from:**

1. Participating in any sport or sporting activity for wage, compensation, or profit. This exclusion does not apply to Part 5, Benefits A, B, or J of the policy.

   Form A71260AR

2. Intentionally self-inflicting bodily Injury or attempting suicide.

3. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

4. Participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term "felony" is as defined by the law of the jurisdiction in which the activity takes place).

5. Having treatment for a mental or nervous disorder or disease.

6. Any loss sustained or contracted due, directly or indirectly, to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).

A "Pre-Existing Condition" is an illness, disease, disorder, or Injury for which, within the six-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received from a Physician. Benefits for a Primary or Secondary Specified Health Event that is caused by a Pre-Existing Condition will not be covered unless the Primary or Secondary Specified Health Event occurs more than 30 days after the Effective Date. The Pre-Existing Condition DOES NOT apply to any Hospital Intensive Care benefits under the policy.

**(6) Renewability:** The policy is guaranteed-renewable for life by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

**RETAIN FOR YOUR RECORDS.**
**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.**
**THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE**
**GOVERNING CONTRACTUAL PROVISIONS.**

COPY

Aflac™

*Rita S. Golden, HIA, AIRC, ACS, MHP*
*Director, Regulatory Compliance*
*Compliance Department*

RECEIVED
MAR 2 3 2006
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

APPROVED
MAR 2 8 2006
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

March 20, 2006

Ms. Rosalind Minor
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC# 60380

**Re: Specified Health Event Policy Forms A71100AR and A71200AR, First-Occurrence Building Benefit Rider A71050, Primary Specified Health Event Recovery Benefit Rider A71051AR, Payroll Application Forms A71001AR and A71001AAR, Non-payroll Application Forms A71002AR and A71002AAR, Request for Change/Application for Reinstatement And/Or Additions Form A71003AR, and Outline of Coverage Forms A71125AR and A71225AR.**

Dear Ms. Minor:

Referenced forms are resubmitted for your review and approval. Per our phone conversation on March 17, 2006, our filing contains individual policies marketed to applicants on a nonpayroll and payroll basis. Although this product may be offered on a payroll or association basis, it is still an individual policy and a policy is issued to each individual applicant. These policies are not issued through a group, association or trust. There are no enrollees or a master policy.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of the Arkansas Insurance Department.

This filing has been prepared by Connie Gates. Should you have any questions concerning this filing, please do not hesitate to contact her by calling collect at (706) 596-5048, by faxing her at (706) 660-7080 or by e-mailing her at cgates@aflac.com. A return envelope is enclosed for your convenience to reply.

Sincerely,

Rita Golden

Rita S. Golden
RG/CG/cg
Enclosures

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *AFLA-126789903* | *State:* | *Arkansas* |
| *Filing Company:* | *American Family Life Assurance Company of Columbus* | *State Tracking Number:* | *46768* |
| *Company Tracking Number:* | *A71000RAPPS* | | |
| *TOI:* | *H07I Individual Health - Specified Disease - Limited Benefit* | *Sub-TOI:* | *H07I.001 Critical Illness* |
| *Product Name:* | *Payroll, Union and Non-payroll Specified Health Event Application Forms* | | |
| *Project Name/Number:* | *A71000 applications/A71001RAR* | | |

# Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---|---|---|---|---|
| 09/10/2010 | Form | Payroll/Union Application | 09/24/2010 | |
| 09/10/2010 | Form | Payroll/Union Application | 09/24/2010 | |
| 09/10/2010 | Form | Non-payroll Application | 09/24/2010 | |
| 09/10/2010 | Form | Non-payroll Application | 09/24/2010 | |
| 09/10/2010 | Form | Request for Change/Application for Reinstatement and/or Additions | 09/24/2010 | |